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Supreme Court, U.S.
FILED

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NO. _____

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1996

TEXAS PHARMACY ASSOCIATION, ET AL.

Plaintiff-Petitioners

VS.

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

Defendant-Respondent

On Petition for Writ of Certiorari From the United States Court of Appeals for the Fifth Circuit

PETITION FOR WRIT OF CERTIORARI

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83 pp

QUESTIONS PRESENTED

1. Article 21.52B of the Texas Insurance Code prohibits a "health insurance policy" from denying a pharmacy or pharmacist the right to participate as a contract provider under the insurance policy if the pharmacy or pharmacist agrees to provide pharmaceutical services that meet all terms and requirements and to include the same administrative, financial, and professional conditions that apply to pharmacies or pharmacists who have been designated as providers under the policy. The dispositive question presented is whether Article 21.52B of the Texas Insurance Code, a mandated provider statute, is preempted by the Employee Retirement Income Security Act of 1974, 88 Stat. 829, *as amended*, 29 U.S.C. § 1001 *et seq.* ("ERISA").

2. Whether the decision of the Fifth Circuit Court of Appeals in this cause holding Article 21.52B to be preempted by ERISA creates a direct conflict with prior decisions of the Fourth Circuit Court of Appeals and the Tenth Circuit Court of Appeals that have held similar mandated provider statutes to be saved from preemption by the ERISA Insurance Savings Clause?

3. Whether the decision of the Fifth Circuit Court of Appeals in this cause holding Article 21.52B to be preempted by ERISA conflicts with prior decisions of the Virginia and Missouri Supreme Courts?

4. Whether the decision of the Fifth Circuit Court of Appeals in this cause holding Article 21.52B to be preempted

by ERISA conflicts with prior decisions of this Court?

5. Assuming that Article 21.52B "relates to" ERISA plans, the question presented is whether the Texas mandated provider statute is saved from preemption as a law concerning the business of insurance pursuant to the ERISA Insurance Savings Clause, 29 U.S.C. § 1144(b)(2)(A) (West 1985)?

6. Assuming that the 1995 re-enactment of Article 21.52B extending the statute's applicability beyond "health insurance policies" and to "managed care plans" renders the statute as one falling outside the scope of the ERISA Insurance Savings Clause, the question presented is whether the provisions of Article 21.52B which relate solely to health insurance policies may be severed from the provisions of the statute which relate to managed care plans, as provided in Chapter 311 of the Texas Government Code?

7. Whether the Fifth Circuit Court of Appeals erroneously construed Article 21.52B and its legislative history to hold that its provisions are not severable under Chapter 311 of the Texas Government Code, such that the statute's terms relating solely to health insurance policies may be severed from the provisions of the statute which relate to managed care plans?

LIST OF PARTIES

The undersigned counsel of record identifies the following listed parties of this case, as well as their counsel of record.

1. Petitioners Texas Pharmacy Association; Ron's Apothecary, Inc.; Tri Cities' Pharmacy, Inc.; City Pharmacy; Hamlin Pharmacy; Anderson Drug; Twelve Oaks Pharmacy; South Houston Pharmacy; Davila Pharmacy; Medical Center Pharmacy; Eilers Discount Pharmacy; Professional Pharmacy; Hart Pharmacy; Hays Hometown Pharmacy; Ward's Pharmacy; Good's Pharmacy; Klein's Discount Pharmacy; Avondale Pharmacy; Home Care Associates, Inc.; Winn's Pharmacy; Tomball Atrium Pharmacy; Rosebud Pharmacy; Maxwell Pharmacy; Save-Mor # 1 Pharmacy, McCrory's Pharmacy; Nichols Southside Pharmacy; Nichols Westwood Pharmacy; Pfennig Prescription Pharmacy; Bel-Aire Drugs; S&L Drug Mart, and Prescription Lab of Spring Branch.

2. Petitioner's Lead Counsel of Record, C. Dean Davis, and counsel Mark Alan Keene of the law firm of Davis & Davis, P.C. of Austin, Texas.

3. The Prudential Insurance Company of America.

4. Respondent's Lead Counsel of Record Daly D.E. Temchine of the law firm of Epstein, Becker & Green, P.C., 1227 25th Street N.W., Suite 700, Washington, D.C. 20037, tel: (202) 861-0900.

5. Counsel for Amicus Curiae American Association of Health Plans, Inc. Joel L. Michaels, Michaels, Whishner, & Bonner, P.C., 1140 Connecticut Ave., N.W.

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1. The written opinion of the United States District Court for the Western District of Texas in this cause is reported at *Texas Pharmacy Assn., et al. v. Prudential Insurance Co.,* 907 F.Supp. 1019 (W.D.Tex. 1995).

2. The written opinion of the Fifth Circuit Court of Appeals in this cause is reported at *Texas Pharmacy Assn., et al. v. Prudential Insurance Co.,* 105 F.3d 1035 (5th Cir. 1997).

STATEMENT OF JURISDICTION

On February 14, 1997, the Fifth Circuit Court of Appeals issued its opinion and judgment affirming and modifying the decision of United States District Court below.

On February 28, 1997, Appellees Texas Pharmacy Assn., et. al filed their Petition for Rehearing which was denied by Order of the Fifth Circuit Court of Appeals dated March 17, 1997.

On March 25, 1997, the Fifth Circuit Court of Appeals issued its judgment as mandate to the United States District Court for the Western District of Texas, Austin Division, and the same was filed by the Clerk of the District Court on March 27, 1997.

This Court's jurisdiction to review the Judgment of the Fifth Circuit Court of Appeals in this case is properly conferred by 28 U.S.C.A. § 1254(1) (West 1993).

CITATION OF STATUTES AT ISSUE

1. Texas Insurance Code, Article 21. 52B (Vernon 1994).

2. Texas Insurance Code, Article 21.52B (Vernon Supp. 1997).

3. 29 U.S.C. § 1144(a) & (b)(2)(A) (West 1985).

4. Texas Government Code, Section 311.032(c) (Vernon 1988).

5. Texas Government Code, Section 311.025 (Vernon 1988).

6. Texas Government Code, Section 312.013 (Vernon 1988).

STATEMENT OF THE CASE

On April 28, 1994, the Texas Pharmacy Association, in a representative capacity on behalf of its members, and thirty (30) independent, community pharmacies, sought a declaratory judgment in the 98th Judicial District Court of Travis County, Texas interpreting Article 21.52B of the Texas Insurance Code (Vernon 1994) as applied to Prudential's admitted conduct in denying pharmacy providers, willing to meet all Prudential's terms and conditions, their statutory right to participate as contract providers under health insurance policies issued by Prudential. (R. 00987-00995). The Plaintiffs specifically sought a declaratory judgment that Prudential's conduct in denying qualified pharmacies and pharmacists their right to participate as contract providers under Prudential's health insurance policies constitutes a violation of Article 21.52B of the Texas Insurance Code. (R. 00011).

The Defendant Prudential removed the case to the United States District Court for the Western District of Texas, Austin Division under 28 U.S.C. § 1331 and 1441(b) (West 1994). (R. 00002). By Order dated September 8, 1994, the District Court held that it possessed diversity of citizenship jurisdiction pursuant to 28 U.S.C. § 1332 (a)(1) and denied the Plaintiff's Motion to Remand. (R. 00110).

Prudential Insurance Company of America is a licensed insurer in Texas and issues health insurance policies as part of its insurance business in the State. (R. 00084-00090). In connection with these health insurance policies, Prudential

maintains several pharmacy provider networks in various Texas cities (one network per city). (R. 00088). The health insurance policies issued by Prudential provide a differential benefit level depending on whether the insured/beneficiary utilizes a contracted pharmacy provider, or a non-contracted provider. (R. 00814). Stated differently, the pharmaceutical benefits to the insured/beneficiary under the insurance contract vary depending on whether a contracted, or non-contracted, pharmacy provider is chosen or selected. (R. 00814). This benefit differential under Prudential's health insurance policies may vary up to thirty percent (30%) with the insured's use of a non-contracted pharmacy. (R. 00814). Accordingly, the insured's cost for pharmacy benefits under Prudential's health insurance policies is more, up to thirty percent (30%) more, if a non-contracted pharmacy provides the pharmaceutical services under the policy, and even if that pharmacy is the patient's choice and can meet all Prudential's terms. (R. 00814 & 01949). Because the cost to the insured for pharmaceutical benefits under the policy is greater if a non-contracted provider is utilized, the insured/beneficiary is financially dissuaded from utilizing non-contract providers. (R. 00814-15).

On March 31, 1995, the Plaintiffs filed their Motion for Summary Judgment under Fed.R.Civ.P. 56. (R. 00701-00744). By Prudential's own judicial admissions, and the testimony of its corporate representative and Vice President Vincent Contorno, incontrovertible evidence was presented that Prudential regularly denies qualified pharmacies and

pharmacists the right to participate as contract providers under its health insurance policies, and does so based on Prudential's determined lack of need for additional providers. (R. 00701-00710). Furthermore, the uncontroverted summary judgment proof established that the individual Pharmacy Plaintiffs had sought to participate as contract providers under Prudential's health insurance policies, and that said requests were refused solely based on Prudential's asserted lack of need for additional providers. (R. 01096-01298). The Plaintiffs also offered as summary judgment proof a certified copy of a letter from the Texas Department of Insurance to Prudential wherein Prudential was advised that Article 21.52B prohibited excluding, as a contract provider, any pharmacy provider willing to meet Prudential's quality and administrative guidelines, regardless of Prudential's self-determined needs. (R. 00964-00969).

The Plaintiffs' claims before the District Court focused exclusively on their efforts to participate as contract providers under Prudential's health insurance policies, and understandably so because Article 21.52B of the Texas Insurance Code, as originally drafted, applied only to "health insurance policies" and did not extend its application to "managed care plans," until the statute was re-enacted wholesale during the 1995 session of the Texas Legislature. The terms of the statute regarding "managed care plans" became effective on September 1, 1995, and apply only to insurance policies or managed care plans issued on or after January 1, 1996, long after Prudential's conduct giving rise

to Plaintiffs' specific claims occurred, and following the District Court's Memorandum Order of October 24, 1995 deciding this cause. Further, the statute expressly continues prior law as applied to policies or plans issued prior to September 1, 1995, the 1995 Act's effective date. *See*, Tex. Ins. Code, art. 21.52B (Vernon Supp. 1997) (Historical Notes Section 7). Therefore, the Plaintiffs' claims challenged Prudential's refusal of their requests to participate as contract providers under its ***health insurance policies*** as a violation of Tex.Ins.Code, Art. 21.52B (Vernon 1994) and did not concern the re-enactment of the statute which expanded its applicability to "managed care plans." (R. 00701-00712; 01096-01304).

By Memorandum Order dated October 24, 1995, the District Court addressed and denied Prudential's claims that the Plaintiffs lacked standing to bring and pursue this declaratory judgment action, that abstention was indicated under these circumstances, and that certain administrative regulations were applicable. (R. 02051-02060). Turning to the substantive issues, the Court held that Article 21.52B of the Texas Insurance Code prohibits Prudential from refusing the Plaintiffs' applications to become contract pharmacy providers based on an asserted lack of need for additional providers. (R. 02057- 02059). The District Court also held that Article 21.52B impacts insured ERISA plans, therefore relates to those plans within the meaning of 29 U.S.C. § 1144(a), and is saved from preemption under the ERISA insurance savings clause of 29 U.S.C. § 1144(b)(2)(A). (R.

02060-02063). The District Court's decision was consistent with that of the Fourth Circuit in *Stuart Circle Hosp. Corp. v. Aetna Health Management*, 995 F.2d 500 (4th Cir. 1993). (R. 02062). On October 24, 1995, the District Court entered Judgment in accordance with its Memorandum Order (R. 02065), and Prudential thereafter filed its Notice of Appeal on November 2, 1995. (R. 02066).

The jurisdiction of the Fifth Circuit Court of Appeals to review an appeal from a final decision of a United States District Court was properly conferred under 28 U.S.C. § 1291 (West 1993). On appeal, Prudential did not contest any of the factual findings and limited its appeal to the singular argument that Article 21.52B of the Texas Insurance Code was preempted by 29 U.S.C. § 1144(a) (West 1985). Focusing on the 1995 expansion of the statute's terms to "managed care plans", Prudential argued that the statute's reference to entities outside the insurance industry caused the entire statute to be preempted by ERISA. Conceding that the statute related to ERISA plans, the Texas Pharmacy Association, et. al argued that the statute was protected from ERISA preemption as a state statute regulating the business of insurance. The TPA also argued that the statute's terms applicable exclusively to health insurance policies were severable from its terms applicable to managed care contracts under Chapter 311 of the Texas Government Code. Therefore, the statute's terms applicable to health insurance policies would survive ERISA preemption even if the statute's terms applicable to managed care contracts

would fail.

Holding that the re-enacted and current version of Article 21.52B of the Texas Insurance Code did not fall within the ERISA insurance savings clause, the Fifth Circuit Court of Appeals held the statute to be preempted in its entirety by opinion dated February 14, 1997. *Texas Pharmacy Assn. v. Prudential Insurance Co.*, 105 F.3d 1035 (5th Cir. 1997). The Fifth Circuit also held that the current version of Article 21.52B was not severable and that it was preempted by ERISA in its entirety, including the provisions relating solely to health insurance policies and entities within the insurance industry. *Id.* In passing on the validity of the prior version of the statute which related solely to "health insurance policies", the Fifth Circuit held that the prior statute was not preempted by ERISA and qualified as a law regulating the business of insurance saved from preemption under the ERISA Insurance Savings Clause. *Id.*

On February 27, 1997, the TPA filed its Petition for Rehearing, which was denied by the Fifth Circuit on March 17, 1997. The Fifth Circuit thereafter issued its Judgment as mandate on March 25, 1997, and this Petition for a Writ of Certiorari followed.

ARGUMENT AND AUTHORITIES

I. Erisa Preemption of Mandated Provider Statutes

A. Conflicting Decisions of Fourth and Tenth Circuits

There is no disagreement regarding the established and uncontroverted facts that Prudential has excluded qualified pharmacy providers from providing pharmaceutical services as contract providers under its health insurance policies. The central question presented is whether Article 21.52B of the Texas Insurance Code, a mandated provider statute, is preempted by the Employee Retirement Income Security Act of 1974, 88 Stat. 829, *as amended*, 29 U.S.C. § 1001 *et seq.* As shown below, the decision of the Fifth Circuit Court of Appeals holding that this Texas Mandated Provider statute is preempted by ERISA directly conflicts with prior decisions of the Fourth Circuit Court of Appeals in *Stuart Circle Hosp. Corp. v. Aetna Health Management*, 995 F.2d 500 (4th Cir. 1993) and the Tenth Circuit Court of Appeals in *Blue Cross and Blue Shield of Kansas City v. Bell*, 798 F.2d 1331 (10th Cir. 1986). This Court must therefore grant this Petition for a Writ of Certiorari in order to resolve a direct conflict between the Fifth Circuit and the Fourth and Tenth Circuit Courts of Appeals.

In *Stuart Circle Hosp. Corp. v. Aetna Health Management*, 995 F.2d 500 (4th Cir. 1993), a Virginia statute regulated the selection of an insurance company's preferred providers by requiring that any provider willing to meet the terms and conditions offered to it could not be excluded from the insurer's preferred provider network. *Id.*

at 500. Aetna marketed it PPO to employee benefit plans and selected as providers for its PPO the same hospitals which were already participating in Aetna's HMO. *Id.* at 501. Stuart Circle Hospital was not selected to be one of Aetna's PPO facilities, although it was willing to meet Aetna's terms. *Id.* Stuart Circle sued Aetna pursuant to the Virginia mandated provider statute which Aetna contended was preempted by ERISA. The District Court held that the Virginia statute was preempted by ERISA since it related to ERISA plans and failed to qualify as an insurance law saved from preemption. *Id.*

On appeal, the Fourth Circuit Court of Appeals found that the Virginia mandated provider statute restricted the ability of an insurance company to limit the choice of providers to those preferred by the insurer, and therefore related to ERISA plans. *Id. at 502.* The Court also concluded, however, that the Virginia statute was saved from preemption as a law regulating the business of insurance. *Id.* In reaching this conclusion, the *Stuart Circle* Court applied the two-part test announced by this Court in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 105 S.Ct. 2380 (1985). First, the Virginia statute met the "common-sense" definition of an insurance statute since it regulated the substantive content of insurance contracts. *Stuart Circle*, 995 F.2d at 502. Secondly, the Court also found that the Virginia statute met the three-part test utilized to determine the scope of the McCarran-Ferguson Act set forth in *United Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129, 102 S.Ct.

3002, 3009 (1982). *Id.* at 503. Noting that none of the three criteria is necessarily determinative in itself, the *Stuart Circle* Court found that the Virginia statute operated to spread a policyholder's risk, that the choice of provider was integral to the insurer-insured relationship, and that the statutory terms were limited to entities within the insurance industry. *Id.* at 503-504.

Accordingly, the Fourth Circuit Court of Appeals has held that a mandated provider statute, similar to the Texas statute at issue, was saved from ERISA preemption as a law regulating the business of insurance. The *Stuart Circle* decision is thus in direct conflict with the decision of the Fifth Circuit Court of Appeal in the case *sub judice* and this Court must therefore exercise its discretionary jurisdiction to grant this Petition for Writ of Certiorari and resolve the conflict among the circuits.

In *Blue Cross and Blue Shield of Kansas City v. Bell*, 798 F.2d 1331, 1333 (10th Cir. 1986), the Tenth Circuit Court of Appeals addressed whether a Kansas mandated benefits and mandated provider statute was saved from ERISA preemption as a law regulating the business of insurance. The *Bell* Court found that this Court's decision in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 105 S.Ct. 2380 (1985) disposed of the any claim that the Kansas mandated benefits statute was preempted by ERISA, and held that such statutes are saved under the ERISA insurance savings clause. In resolving whether the Kansas mandated provider statute was saved from ERISA

preemption, the *Bell* Court relied upon this Court's analysis in *Metropolitan Life*. *Bell*, 798 F.2d at 1334.

The *Bell* Court found that the insured's choice of a provider constitutes the essence of the coverage bargained for as the statute operated to spread or transfer the policyholder's risk. *Id*. at 1335. The Court also readily found that the selection of a particular provider is as integral to the bargained-for coverage as the coverage itself, and therefore the mandated provider statute regulated a matter integral to the insurer-insured relationship. *Id*. Lastly, the Court considered whether the practice was limited to entities within the insurance industry and found that the mandated provider statute imposed requirements on insurers with the intent of affecting the relationship between the insurer and policyholder; therefore, the challenged practice was essential to the insurance policy itself. *Id*.

The *Bell* Court thus concluded that the Kansas mandated benefit and mandated provider statutes constituted the very type of state regulation that centers around the contract of insurance and therefore was saved from ERISA preemption as state regulation of the business of insurance. *Id*. at 1336. Therefore, the Tenth Circuit Court of Appeals has held that a mandated provider statute, substantively similar to Article 21.52B of the Texas Insurance Code, is saved from ERISA preemption as a law regulating the business of insurance. This Court must consequently grant this Petition for a Writ of Certiorari to resolve a conflict between the aforementioned decision by the Tenth Circuit

Court of Appeals and that of the Fifth Circuit Court of Appeal in the case at bar.

B. Conflicting Decisions of State Supreme Courts

In *Blue Cross & Blue Shield of Virginia v. St. Mary's Hospital*, 245 Va. 24, 27, 426 S.E.2d 117, 118 (Va. 1993), the Virginia Supreme Court was confronted with whether the same Virginia mandated provider statute at issue in Stuart Circle, supra. was preempted by ERISA. The excluded hospital provider, St. Mary's Hospital of Richmond, Inc., sought declaratory relief that Blue Cross & Blue Shield ("Blue Cross") violated the Virginia mandated provider statute. 245 Va. at 28, 426 S.E.2d at 119. The court found that Blue Cross marketed a PPO in Virginia and encouraged patients to use its preferred providers by imposing a penalty of approximately 30% on patients who used nonpreferred providers. 245 Va. at 29, 426 S.E.2d at 119. In analyzing whether the Virginia mandated provider statute was preempted by ERISA, as Blue Cross had contended, the court found this Court's decision in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 105 S.Ct. 2380 (1985) to be similar to the issue at hand. 245 Va. at 32, 426 S.E.2d at 121.

Noting that the presumption is against preemption, this Court in *Metropolitan Life* held that a Massachusetts mandated benefits law, as applied, regulated insurance within the meaning of the ERISA insurance savings clause. 471 U.S. at 758, 105 S.Ct. at 2398. Guided by *Metropolitan Life*, the Virginia Supreme Court found that the State's

mandated provider statute was part of the Insurance Code and regulated the manner in which a PPO may be established and operated. 245 Va. at 332, 426 S.E.2d at 122. The Virginia Supreme Court thus held that Virginia's mandated provider statute met the "common-sense" definition of laws regulating the business of insurance and was consequently saved from preemption by ERISA's insurance savings clause. *Id.*

The Virginia Supreme Court's decision regarding the scope and applicability of ERISA's insurance savings clause to mandated provider statutes conflicts with the Fifth Circuit's decision holding that Texas' mandated provider statute is preempted by ERISA. The Virginia Supreme Court has thus decided an important federal issue that conflicts with the determination of a federal circuit court of appeals on the same matter. This Court must grant this Petition for Writ of Certiorari to resolve the conflicting decisions on this important federal issue.

In *Blue Cross Hosp. Service, Inc. v. Frappier*, 698 S.W.2d 326 (Mo. 1985), health service corporations challenged a Missouri mandated provider statute regarding chiropractic and pharmaceutical care. The Missouri statutes required health insurers to allow insureds to select chiropractors to render covered services within the scope of their licenses, to provide like coverage for psychologists, and to permit an insured to assign their right to reimbursement for covered medications to pharmacists, whether or not the pharmacist had a contract with the insurer or health service

organization. *Id.* at 327. The Missouri Supreme Court received the case on remand from this Court to consider whether the mandated provider statutes were preempted by ERISA in light of the Court's recent decision in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 105 S.Ct. 2380 (1985).

The *Frappier* court found that the Missouri mandated provider and assignment statutes clearly related to the benefits available to the insured under health insurance contracts. *Frappier*, 698 S.W.2d at 327. The Missouri Supreme Court noted that without the statutes the insured could obtain the services of chiropractors and psychologists only by paying for them, even if the insured concluded that the services of these professionals provided the most effective therapy. *Id.* Also, without the statutes, an insured might be compelled to obtain medicines from a pharmacy at a remote location, or which ran hours of operation inconvenient to the insured. *Id.* After reviewing these practical considerations that bear on whether a statute regulates the business of insurance, the *Frappier* court saw "no viable distinction between the mandated benefit provisions involved in *Metropolitan Life* and our mandated provider statutes." *Id.* The Missouri Supreme Court accordingly held that the challenged mandated provider statutes regulate insurance so as to be immune from ERISA preemption.

As explained in detail below, the Texas mandated pharmacy provider statute also constitutes the regulation of

the business of insurance and is properly saved from preemption by ERISA's insurance savings clause. Therefore, the *Frappier* decision by the Missouri Supreme Court decides the important federal issue of whether mandated provider statutes are saved from preemption by the ERISA insurance savings clause in a manner at odds with the decision of the Fifth Circuit Court of Appeals in this cause. This Court should therefore exercise its discretionary jurisdiction to grant this Petition for Writ of Certiorari and provide needed uniformity to this body of federal law.

C. Conflict with Decisions of the United States Supreme Court

In *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 733, 105 S.Ct. 2380 (1985), this Court considered whether a state statute which mandated a minimum level of psychological benefits regulated insurance within the meaning of the ERISA savings clause. Employing a two part analysis, this Court first took a "common sense" approach to the question of whether the Massachusetts mandated benefit law regulated insurance. *Id.* at 741, 105 S.Ct. at 2389. The Court determined that because the Massachusetts statute regulated the substantive terms of insurance contracts, it regulated insurance within the common sense meaning of the ERISA insurance savings clause. *Id.* The Court further recognized that ERISA's "deemer clause makes explicit Congress' intention to include laws that regulate insurance contracts within the scope of insurance laws preserved by the savings clause." *Id.* at 741, 105 S.Ct. at 2390. In fact,

as this Court clearly recognized, nearly every court that has addressed the question has concluded that laws regulating the substantive content of insurance contracts are laws that regulate insurance within the scope of the savings clause. *Id.* at 741 n. 18, 105 S.Ct. at 2390 n. 18. Thus, a state law which regulates the substantive content of insurance contracts is, under the "common sense" view, a law regulating insurance within the scope of ERISA's insurance savings clause. This Court has also held that laws aimed at regulating the insurer-policyholder relationship (whether directly or indirectly), and the type of policy which could be issued, are exempt from preemption as state regulation of the business of insurance. *S.E.C. v. National Securities, Inc.*, 393 U.S. 453, 460, 89 S.Ct. 564, 569 (1969).

After finding that the Massachusetts mandated benefit law met the "common-sense" definition of a law regulating insurance, the Court next applied a three-part test to determine whether the conduct regulated constituted the business of insurance. *Metropolitan Life Ins. Co.*, at 744, 105 S.Ct. at 2391. This three-part test inquires (1) whether the practice has the effect of transferring or spreading a policyholder's risk; (2) whether the practice is an integral part of the policy relationship between the insurer and the insured; and (3) whether the practice is limited to entities within the insurance industry. *Id.* (citing *United Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129, 102 S.Ct. 3002, 3008 (1982)). No one factor is dispositive, but rather all are instructive on whether the challenged law regulates the business of

insurance. *Id.* at 129, 102 S.Ct. at 3009. Furthermore, the question is not whether the statute names entities outside the insurance industry, but whether the practice at issue meets this instructive three-part test. *Id.*

Applying this two-step analysis, the issue before this Court is whether Article 21.52B regulates insurance within the meaning of ERISA's insurance savings clause. First, it is clear that Article 21.52B meets the "common sense" definition of a law regulating insurance. The Texas statute clearly regulates the substantive content of insurance policies, the type of policy that may be issued in the state, and therefore regulates insurance within the common sense view of the term. *Metropolitan Life Ins. Co.*, 471 U.S. at 740-744, 105 S.Ct. 2389-91. Additionally, Article 21.52B is part of a comprehensive code regulating the business of insurance in Texas, it regulates the relationship between insurer and insured, the type of policy which may be issued between them, and therefore falls within the core of the business of insurance. *S.E.C.*, 393 U.S. at 460, 89 S.Ct. at 569. Thus, a common-sense view of Article 21.52B compels the conclusion that it regulates insurance contracts within the scope of ERISA's savings clause. *Metropolitan Life Ins. Co.*, 471 U.S. at 741, 105 S.Ct. at 2390. By regulating the substantive content of insurance policies in Texas, Article 21.52B meets the common sense definition of insurance regulation and accordingly falls within the scope of ERISA's insurance savings clause.

Secondly, Article 21.52B passes muster under the

three criteria the *Metropolitan Life* Court derived from *Pireno, supra.* As the *Pireno* Court noted, "[n]one of these criteria is necessarily determinative in itself," and are not to be rigidly applied. *Pireno*, 458 U.S. at 129, 102 S.Ct. at 3009; *Workers & Employers Arizona Health & Welfare Trust v. Pacyga*, 801 F.2d 1157, 1160 (9th Cir. 1986) (no one factor is dispositive, rather each is instructive). The Texas statute satisfies the first criterion in "transferring or spreading a policyholder's risk." Part of a policyholder's risk entails the type of illness and injury covered by the contract, the provisions for treatment, and the cost of treatment. *Stuart Circle Hosp. Corp. v. Aetna Health Management*, 995 F.2d 500, 503 (4th Cir. 1993). Article 21.52B directly affects the cost of treatment available to the insured, and thereby impacts the policyholder's risk under the contract. Under Article 21.52B § 2(a), an insurer may not limit a beneficiary's choice of pharmacy provider under the policy, nor may the insurer deny to a pharmacy provider the right to render services under the policy as a contract provider if the provider is willing to meet all terms and conditions imposed on providers designated under the policy. If an insurer denies such a provider the right to participate as a contract provider under the policy, and render pharmaceutical services on such terms, the insurer restricts or limits the policyholder's benefits under the contract.

As stated previously, a policyholder's prescription benefits under the policy vary depending on whether a contracted or non-contracted provider is utilized. When a

non-contracted provider is selected by the policyholder, the policyholder receives a more costly prescription benefit under the policy, and thus must assume the additional cost occasioned by the use of the non-contracted provider. This additional cost is imposed on the policyholder even if the non-contracted provider selected is determined to provide the best pharmaceutical care, can meet all Prudential's terms, and a designated provider is either inaccessible or unable to dispense the medications required. By contrast, Article 21.52B redistributes this cost and the risk of incurring the same by mandating that the insurer provide the full prescription benefit available under the policy upon the insured's selection of any fully qualified and willing pharmacy provider. The additional cost to the insured for prescription benefits when a non-contracted provider is selected is shifted to the insurer under Article 21.52B § 2 if the provider is willing to meet the insurer's terms and conditions. In this manner, Article 21.52B transfers or spreads to all insureds the cost component of a policyholder's risk of shouldering the differential cost of selecting non-contracted providers to provide the benefits under the contract. In these respects, the statute meets the first of the three *Pireno* factors in transferring or spreading a policyholder's risk. Furthermore, the "insured's right to choose the type of practitioner to fulfill the agreed upon coverage must figure into, and play a part in, 'the spreading and underwriting of a policyholder's risk.'" *Blue Cross and Blue Shield of Kansas City v. Bell*, 798 F.2d 1331, 1335 (10th Cir. 1986).

The Texas statute clearly concerns an integral part of the policy relationship between the insured and insurer, and therefore satisfies the second *Pireno* factor. As the Fourth Circuit Court of Appeals recognized, "treatment and cost are important components of health insurance" and "[r]egulations governing these components...are integral parts of the relationship between insurer and insured." *Stuart Circle*, 995 F.2d at 503. In fact, this Honorable Court in *Metropolitan Life* observed that mandated provider statutes were among the state laws which regulate the substantive terms of insurance contracts. *Metropolitan Life Ins. Co.*, 471 U.S. at 729 n. 9, 105 S.Ct. at 2384 n.9. The freedom to choose a health care provider is inextricable from the nature of coverage provided, and the Texas mandated provider statute thus concerns an integral part of the insurer-insured relationship. *Bell*, 798 F.2d at 1335.

Finally, the practice regulated by the Texas statute, as applicable in this litigation, is limited to a practice within the insurance industry, the issuance of health insurance policies. As stated previously, the provisions of the statute at issue were expressly limited to "health insurance policies" and the Plaintiffs' claims were exclusively so presented. While the 1995 reenactment of Article 21.52B extended its application to managed care plans, the precise issue in this case is whether an insurer's admitted exclusion of qualified providers from providing covered services under health insurance policies violates the statute's terms on these matters. To strike down Article 21.52B simply because it now makes

reference to "managed care plans" would constitute an improper and unduly rigid application of the three-part test explained by this Court in *Metropolitan Life* Ins. Co., supra. Clearly, the practice at issue in this litigation is exclusively focused upon services rendered under health insurance policies and the terms of the Texas mandated provider statute in that regard undoubtedly constitute the regulation of insurance saved from ERISA preemption.

In the case at bar, the Fifth Circuit Court of Appeals "held that the statute was preempted because it did not meet the third requirement of the three-part (*Pireno*) test, that it apply exclusively to entities within the insurance industry. *Texas Pharmacy Assn. v. Prudential Ins. Co.*, 105 F.3d 1035, 1038 (5th Cir. 1997). By asking whether the statute, rather than the practice at issue, applies exclusively to insurance entities, the Fifth Circuit Court of Appeals has misconstrued and therefore misapplied the precedent of this Court in *Metropolitan Life Ins. Co. and Pireno, supra.* This Court should thus grant this Petition for Writ of Certiorari to clarify, in light of the Fifth Circuit's opinion, the test to determine whether a particular practice regulated by statute constitutes the regulation of the business of insurance.

II. Severability of the Texas Mandated Provider Statute

In striking down Texas' mandated provider statute in all its applications, the Fifth Circuit Court of Appeals erroneously concluded that the statute's provisions regulating the content of health insurance policies were not severable from its provisions regulating the terms of managed care

contracts. *Texas Pharmacy Assn. v. Prudential Ins. Co.*, 105 F.3d 1035, 1039 (5th Cir. 1997). The Fifth Circuit candidly recognized that its "court has recognized as an independent requirement for the applicability of the savings clause that the state statute 'be limited to entities within the insurance industry.'" *Id.* (citing, *CIGNA Healthplan of Louisiana v. Louisiana*, 82 F.3d 642 (5th Cir. 1996), *cert. denied*, -- U.S. --, 117 S.Ct. 387 (1996)). The Fifth Circuit has therefore established a new requirement for the applicability of the ERISA insurance savings clause, a requirement not established by the precedent of this Court.

No longer is it sufficient in the Fifth Circuit that the *practice* at issue and regulated by the statute is directed exclusively to entities within the insurance industry, as this Court held in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 733, 744, 105 S.Ct. 2380, 2391 (1985) and *United Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129, 102 S.Ct. 3002, 3008 (1982); rather, the party seeking protection from ERISA preemption must also independently establish that the statute makes no reference in any of its portions or provisions to entities determined to be outside the insurance industry. This Court must therefore grant this Petition for a Writ of Certiorari in order to prevent an expansion of the *Pireno* test that is without precedent or authority.

Furthermore, in holding that the terms of the Texas mandated provider statute applicable to health insurance policies were not severable from its terms applicable to

managed care plans, the Fifth Circuit Court of Appeals erroneously interpreted the statute's legislative history and current terms. Specifically, the Fifth Circuit Court of Appeals held that the statute's original enactment in 1991 which contained an express non-severability provision was applicable to the current version of the statute which was completely re-enacted in 1995. *Texas Pharmacy Assn.*, 105 F.3d at 1039.

During the 71st Legislative Session in 1991, the Texas Legislature passed Article 21.52B which contained an uncodified provision regarding the non-severability of the statute's provisions. This section provided that "[i]f any provision of this Act or if application to any person or circumstance is held invalid, this entire Act is invalid and to that end the provisions of this Act are not severable." Acts 1991, 72nd Leg., ch. 182, Section 3, eff. Sept. 1, 1991. In 1995, the Texas Legislature ***completely re-enacted*** Article 21.52B with the expanded application of its provisions to managed care plans. *See*, Acts 1995, 74th Leg., ch. 852, eff. Sept. 1, 1995. The Legislature did not simply amend Article 21.52B in 1995, thereby leaving prior, unamended provisions intact. Rather, the Legislature enacted an entirely separate and new statute that applied to insurance contracts (as did the prior statute) and managed care plans. The absence of the prior nonseverability provision in the 1995 reenactment also makes legislative sense, especially considering the statute's expanded application to managed care plans. The Legislature obviously intended the statute's

applicability to health insurance contracts, its exclusive focus prior to 1995, to survive any invalidity generated by the 1995 reenactment and expansion of its application to managed care plans.

Moreover, and as enacted in 1995, Article 21.52B contains no express provisions regarding the severability of the statute, and therefore differs significantly from the previous enactment of the statute in 1991. Because the 1995 version of Article 21.52B (a wholesale re-enactment and extension of prior law) does not contain any express severability provision, its terms are severable under Section 311.032(c) of the Texas Government Code. It is further clear that the 1995 reenactment of Article 21.52B is a legislative enactment later in time than the passage of the 1991 statute. Under Section 311.025 of the Texas Government Code, "the statute latest in enactment prevails" when attempting to reconcile conflicting statutory provisions.

Moreover, because the 1995 statute contains no severability provision, and the 1991 statute contains an uncodified non-severability provision, the two enactments conflict in this regard. The 1995 re-enactment of the statue, being later in time, controls the disposition of this question. Thus, the current version of Article 21.52B, containing no express statement regarding severability, controls over the prior version of the statute, and is therefore severable under Section 311.032(c) of the Texas Government Code. *See, Jessee v. De Shong*, 105 S.W. 1011 (Tex.Civ.App. - 1908, no writ) (in reenacting a statute, omissions of material words

indicate an intent to change the law); *Fort Worth & D.C. Ry. Co. v. Welch*, 183 S.W.2d 730 (Tex.Civ.App. - Amarillo 1944, writ ref'd) (a revision of statutes implies a reexamination and restatement of the law in a connected or improved form, with or without material changes, and it will be presumed that Legislature knew consequences of action taken).

When the Texas Legislature re-enacted Article 21.52B in 1995, they did so by eliminating any prior non-severability provisions. The absence of such non-severability language makes logical sense in light of the extension of the statute's prohibitions to the managed care setting. Should this extension be invalid, as found by the Fifth Circuit Court of Appeals, the remaining portions of the statute dealing with health insurance contracts should be severed and clearly survive, as there is no express provision to the contrary. The Fifth Circuit's holding that the non-severability provisions of the 1991 statute control the severability of the 1995 statute ignores the controlling legislative history, the applicable sections of the Government Code, and contravenes the intent of the Texas Legislature in re-enacting Article 21.52B without such a severability provision.

Under Sections 311.032 and 312.013 of the Texas Government Code, the current version of Article 21.52B contains no provisions regarding non-severability and is therefore severable and enforceable in its application to health insurance policies, as the District Court held. Furthermore, the 1995 statute, which contains no statement

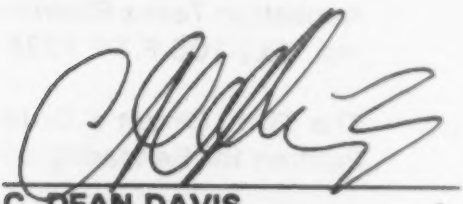
regarding severability, clearly controls over prior enactments. Therefore, the terms of Article 21.52B applicable to health insurance contracts are severable from the provisions addressing managed care plans, and survive ERISA preemption as state regulation of the business of insurance. The Fifth Circuit erroneously interpreted the statute's legislative history and the controlling provisions of the Texas Government Code in determining that the current version of Article 21.52B's provisions relating exclusively to health insurance contracts are void due to the statute's severable application to managed care plans. On the important issue of the scope of federal preemption, this Court should grant this Petition for Writ of Certiorari in order to prevent an erroneous development of federal law and to prevent an undue intrusion upon the authority of the several States to regulate the business of insurance.

CONCLUSION

The Fifth Circuit's opinion in this case conflicts directly with prior opinions of the Fourth and Tenth Court of Appeals, with decisions of the Virginia and Missouri Supreme Courts, as well as with precedent of this United States Supreme Court. This Petition for Writ of Certiorari should be granted in order to resolve this conflict and determine an important issue of federal law. Furthermore, the Fifth Circuit Court of Appeals erroneously concluded that the Texas mandated provider statute, Article 21.52B of the Texas Insurance Code, was preempted in its application to health insurance policies, and therefore this Court should grant this

Petition for Writ of Certiorari, reverse the decision of the Court of Appeal, and affirm the decision of the District Court below, for which relief Petitioners pray.

Respectfully submitted,



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APPENDIX

1. The Opinion of the Fifth Circuit Court of Appeals in *Texas Pharmacy Assn. v. Prudential Ins. Co.*, 105 F.3d 1035 (5th Cir. 1997).

2. The Fifth Circuit's Order denying Appellees' Petition for Rehearing on March 17, 1997.

3. The Judgment of the Fifth Circuit Court of Appeals on which review is sought.

4. Texas Insurance Code, Article 21.52B (Vernon 1994) and Historical and Statutory Notes.

5. Texas Insurance Code, Article 21.52B (Vernon 1997) and Historical and Statutory Notes.

6. 29 U.S.C. § 1144(a) & (b)(2)(A) (West 1985).

7. Texas Government Code, Section 311.032(c) (Vernon 1988).

8. Texas Government Code, Section 311.025 (Vernon 1988).

9. Texas Government Code, Section 312.013 (Vernon 1988).

1. The Opinion of the Fifth Circuit Court of Appeals in *Texas Pharmacy Assn. v. Prudential Ins. Co.*, 105 F.3d 1035 (5th Cir. 1997).

TEXAS PHARMACY ASSOCIATION, et al., Plaintiffs,

Texas Pharmacy Association, formerly known as Texas Pharmaceutical Assn., Ron's Apothecary, Inc., Tri Cities' Pharmacy, Inc., City Pharmacy, Hamlin Pharmacy, Anderson Drug, Twelve Oaks Pharmacy, South Houston Pharmacy, Davila Pharmacy, Medical Center Pharmacy, Eilers Discount Pharmacy, Professional Pharmacy, Hart Pharmacy, Hays Hometown Pharmacy, Ward's Pharmacy, Good's Pharmacy, Klein's Discount Pharmacy, Avondale Pharmacy, Home Care Associates, Inc., Winn's Pharmacy, Tomball Atrium Pharmacy, Rosebud Pharmacy, Maxwell Pharmacy, Save-Mor #1 Pharmacy, McCrory's Pharmacy, Nichols Southside Pharmacy, Nichols Westwood Pharmacy, Pfenning Prescriptions Pharmacy, Bel-Aire Drugs, S & L Drug Mart and Prescription Lab of Spring Branch, Plaintiffs- Appellees,

v.

The PRUDENTIAL INSURANCE COMPANY OF AMERICA, Defendant-Appellant.

No. 95-50807.

United States Court of Appeals, Fifth Circuit

Feb. 14, 1997

Appeal from the United State District Court for the Western District of Texas.

Before REAVLEY, GARWOOD and BENAVIDES, Circuit Judges.

REAVLEY, Circuit Judge:

This appeal concerns whether a Texas "any willing provider" statute applicable to pharmacies is preempted by the Employee Retirement Income Security Act (ERISA).[1] The

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[1]. 29 U.S.C. §§1001-1461.

Texas Pharmacies brought suit in Texas state court seeking a declaratory judgment that the statute compels appellant Prudential Insurance Company Of america (Prudential) to contract with any pharmacy in Texas willing to accept Prudential's contractual terms and conditions. Prudential removed the case to federal court, claiming that the statute is preempted by ERISA. The district court ruled by summary judgment that the 1991 statute is not preempted because it regulates insurance under ERISA'S savings clause. We hold that the current statute is preempted, but we agree that the statute prior to 1995 amendments is not preempted.

BACKGROUND

The essential facts are few and undisputed. Prudential offers group health insurance policies to employers in Texas. It also contracts to provide administrative services only to self-funded employer health plans. For participants and beneficiaries of both types of plans-the employees and their covered family members-Prudential maintains several health care networks, including pharmacy networks. In these networks, Prudential contracts with certain pharmacies and allows participants to fill their prescriptions at these pharmacies at predetermined dispensing fees and drug prices. Prudential claims that the networks provide for quality control and lower prices.

In 1991, the Texas legislature passed an "any willing provider" statute pertaining to pharmacies. The statute was amended in 1995 and now provides in part:

> Sec. 2. (a) A health insurance policy *or managed care plan*...may not:
>
> (1) prohibit or limit a person who is a beneficiary of the policy from selecting a pharmacy or pharmacist of the person's choice to be a provider under the policy to furnish pharmaceutical services offered or provided by that policy or interfere with that person's selection of a pharmacy or pharmacist:

(2) deny a pharmacy or pharmacist the right to participate as a contract provider under the policy *or plan* if the pharmacy or pharmacist agrees to provide pharmaceutical services that meet all terms and requirements and to include the same administrative, financial, and professional conditions that apply to pharmacies and pharmacists who have been designated as providers under the policy *or plan*;

(3) require a beneficiary of a policy *or participant in a plan* to obtain or request a specific quantity or dosage supply of pharmaceutical products.[2]

The emphasized portions of the statute were added by the 1995 amendments. The amendments also added a section broadly defining a "managed care plan" to include "a health maintenance organization, or another organization that, under a contract or other agreement entered into with a participant in the plan...provides health care benefits...."[3]

The parties argue the effect of the 1995 statute in this appeal and, unless otherwise announced, it is that current statute we will discuss.

The effect of the statute is that any pharmacist willing to abide by the terms of a Prudential network contract must be admitted to the network. The statute declares void any provision of a health insurance policy or managed care plan that conflicts with it.[4] The statute does however exempt from the any-willing-provider requirement "a self-insured

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[2]. TEX. INC. CODE ANN. art. 21.52b, § 2 (West Supp.1977)

[3]. *Id.* § 1(6).

[4]. *Id.* § 3.

employee benefit plan that is subject to [ERISA]."[5]

DISCUSSION

A. *ERISA's Preemption Clause*

[1] Prudential argues that the Texas statute is preempted by ERISA. We agree that the current statute is preempted. ERISA's preemption clause provides that it preempts any and all state laws which "relate to" an ERISA benefit plan.[6] The Supreme Court has held that this preemption clause is "deliberately expansive"[7] and that a state law relates to an ERISA plan "if it has a connection with or reference to such a plan."[8] We have held that the preemption clause "is to be construed extremely broadly."[9]

As the district court found and as the TPA concedes, the state statute relates to ERISA benefit plans under the preemption clause. Garden variety employer health insurance plans, which are regulated by the Texas statute, are "employee benefit plans" under ERISA, defined to include "any plan .... established or maintained by an employer ...for the purpose of providing ...through the purchase of insurance or otherwise.... medical, surgical, or hospital care

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[5]. *Id.* § 5.

[6]. 29 U.S.C. § 1144(a).

[7]. *Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41, 46, 107 S.Ct. 1549, 1552, 95 L.Ed.2d 39 (1987).

[8]. *Shaw v. Delta Air Lines, Inc.,* 463 U.S. 85, 96-97, 103 S.Ct. 2890, 2900, 77 L.Ed.2d 490 (1983).

[9]. *Corcoran v. United HealthCare, Inc.,* 965 F.2d 1321,1328 (5th Cir.), *cert. denied,*506 U.S. 1033, 113 S.Ct. 812 121 L.Ed.2d 684 (1992).

or benefits, or benefits in the event of sickness..."[10] In *CIGNA Healthplan of Louisianan v. Louisiana*,[11] discussed below, we held that a Louisiana any-willing-provider statute fell within the preemption clause.[12] As with the Louisiana statute at issue in CIGNA, the Texas statute related to ERISA plans because it "eliminates the choice of one method of structuring benefits,"[13] by prohibiting plans from contracting with pharmacy networks that exclude any willing provider.

B. *ERISA's Savings Clause*

1. *The Current Statute*

Although the state statute relates to ERISA benefit plans under ERISA's preemption clause, the TPA argues that it nevertheless is not preempted because of ERISA's savings clause, which provides that "nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance...."[14] The TPA contends that the statue, which exempts employer self-insured ERISA plans, falls within the savings clause.

We hold that the statue does not fall within the savings clause, as this result is compelled by our recent decision in *CIGNA*, where we held that a Louisiana any-willing-provider statute did not fall within the savings clause. The Louisiana statute provided that any willing provider may

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[10]. 29 U.S.C. § 1002(1)(A).

[11]. 82 F.3d 642 (5th Cir.), *cert. denied*,---U.S.---, 117 S.Ct. 387, 136 L.Ed.2d 304 (1996).

[12]. *Id.*at 647-49.

[13]. *Id.* at 648.

[14]. 29 U.S.C. § 1144(b)(2)(A).

join a preferred provider organization if he agrees to the terms and conditions of the contract between a preferred provider organization and its health care providers.[15] We followed the test given in *Metropolitan Life Ins. Co. v. Massachusetts*[16] in deciding whether the statute fell with the savings clause:

> In [*Metropolitan Life*], the Supreme Court delineated the requirements that a statute must meet to come within the insurance facet of the savings clause. As we have noted in prior opinions, the Court took a conjunctive two-step approach: "First, the court determined whether the statute in question fitted the common sense definition of insurance regulation. Second, it looked at three factors: (1) Whether the practice (the statute) has the effect of spreading the policyholders' risk; (2) whether the practice is an integral part of the policy relationship between the insurer and the insured; and (3) whether the practice is limited to entities within the insurance industry. If the statute fitted the common sense definition of insurance regulation and the court answered 'yes' to each of the questions in the three part test, then the statute fell within the savings clause exempting it from ERISA preemption." Thus, if a statute fails either to fit the common sense definition of insurance regulation or to satisfy any one element of the three-factor Metropolitan Life test, then the statute is not exempt from preemption by the ERISA insurance

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[15]. LA.REV.STAT. ANN. § 40:2202(5)(c) ("No licensed provider ... who agree to the terms and conditions of the preferred provider contract shall be denied the right to become a preferred provider to offer health services within the limits of the license.").

[16]. 471 U.S. 724, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985).

savings clause.[17]

We held that the statute was preempted because it did not meet the third requirement of the three-part test, that it apply exclusively to entities within the insurance industry:

> When we begin to apply that test to Louisiana's Any Willing Provider Statute, we may start and finish with the third factor of Metropolitan Life test: On its face, Louisiana's statute obviously is not "limited to entities within the insurance industry." Even though the statute lists insurers as one group covered by its terms, it also specifies, in a non-exclusive list, that it applies to "self-funded organizations, Taft-Hartley trusts, or employers who establish or participate in self funded trust or programs," as well as "health care financiers, third party administrators, providers, or other intermediaries." As the statute fails to meet the third factor of the Metropolitan Life test, we affirm the district court's holing that the statute is not saved from preemption by the insurance exception of § 514(b) of ERISA.[18]

Id.

Applying the same analysis, the Texas statute in the present case does not fall within the savings clause because it is not limited to entities within the insurance industry. Instead, it also applies to health maintenance organizations (HMOs), preferred provider organization (PPOs), and other organizations that provide health care services. Indeed since the statute defines managed care providers to include HMOs, PPOs or "another organization" that provides health care benefits, it applies to ERISA benefit plans themselves. The "deemer provision" at ERISA prohibits treating ERISA

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[17]. *CIGNA*, 82 F.3d at 650 (quoting *Tingle v. Pac. Mut. Inc. Co.*, 996 F.2d 105, (5th Cir. 1993)).

[18]. *CIGNA*, 82 F.3d at 650.

employee benefit plans themselves as being engaged in the business of insurance. It states that an employee benefit plan ... [shall not] be deemed to be an insurance company or to be engaged in the business of insurance ... for purposes of any law of any State purporting to regulate insurance companies..."[19]

Several examples demonstrate that the statute is not directed exclusively to insurers. If an individual, outside of his employment, signs up with an HMO, he may or may not have insurance, yet under the statute the HMO would be subject to the any willing-provider provision. Similarly, a self insured employer is not subject to the any-willing-provider provision, but if the employer signed up with an HMO or PPO, those organizations would be subject to the statute, even if there is no insurance company involved. If a group of pharmacies wanted to offer discount prescription services to an employer or other organization, such a group would constitute a PPO or "other organization" subject to the any-willing-provider requirement, whether or not an insurance company was involved. And if an employer offered a medical plan through an insurance company that did not pay for prescriptions. but wanted to contract with a pharmacy to provide prescription services outside of the insurance plan, the employer would be subject to the statute. Under the statute, the employer would be "another organization" providing health care benefits and would not be self-insured under the statutory exception to the preferred-provider-provision.

[2] The TPA, in the final footnote of its brief, suggests that if the statute is preempted because it does not apply exclusively to insurers, then we should find preemption only insofar as the statute regulates noninsurers. Stated another way, the TPA suggests that the preempted portions of the statute are severable. We reject this argument for three reasons. First, *CIGNA* implicitly rejected this argument. It did

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[19]. 29 U.S.C. § 1144(b)(2)(B).

not hold the statute valid as to PPOs offered by or affiliated with insurers. Second, our court has recognized as an independent requirement for the applicability of the savings clause that the state statute "be limited to entities within the insurance industry."[20] This requirement would be meaningless if a court could simply sever out those portions of the statute which applied to noninsurance entitles.

[3] Third, the Texas statute is not severable because it so states. Whether portions of a state statute found to contravene federal law are severable is a question of state law.[21] The Texas statute, as originally enacted in 1991, provides that "[i]f any provision of this Act or if application to any person or circumstance is held invalid, this entire Act is invalid and to that end the provisions of this Act are not severable."[22] There is no indication in subsequent amendments to the statute that this provision does not continue to express the intention of the Texas legislature. Under the Texas Code Construction Act, a Texas statute should be deemed severable if the invalidity of one provision does not affect the other provisions, unless it has an express provision for severability or nonseverability.[23] Here there is an express nonseverability provision.

We note an irony in the result reached. Insurance companies were no doubt the principal proponents of the McCarran-Ferguson Act and the ERISA savings clause, because they did not want federal regulation of their industry.

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[20]. *CIGNA*, 82 F.3d at 650; *Tingle,* 996 F.2d at 108.

[21]. *United States Dep't of Treasury v. Fabe,*508 U.S.491, 508-10 & n. 8, 113 S.Ct. 2202, 2212 & n.8, 124 L.Ed.2d 449 (1993).

[22]. TEX.INC.CODE.ANN. art. 21.52B note (West Supp. 1997).

[23]. TEX. GOV'T CODE § 311.032.

Here, however, the insurance company is arguing against state regulation and in favor of federal preemption. There is room to doubt if ERISA's drafters intended that it would preempt any-willing-provider statutes. We nevertheless conclude that the result in this case is compelled by the unmistakable breadth of ERISA preemption recognized by the Supreme Court. A different result will require further guidance from the Supreme Court or further action from Congress.

2. *The Prior Statute*

[4] We question whether a ruling on the validity of the old statute is of much value to the parties, but note that the 1995 amendments apply only to "an insurance policy or evidence of coverage under a managed care plan that is delivered, issued for delivery, or renewed on or after January 1, 1996."[24] Conceivably there are unexpired contracts covered by the old statute.

We conclude that the old statute is not preempted by ERISA. Under the first step of the *Metropolitan Life* test, discussed *supra*, we are satisfied that the statute fits within the common sense definition of insurance regulation. It directly regulates the terms of health insurance policies that can be offered in Texas, by, among other things, disallowing (1) policies that prohibit a beneficiary from selecting a pharmacy of the beneficiary's choice, (2) policies that deny willing pharmacists from participating as a contract provider under the policy, and (3) policies that require a beneficiary of a policy to obtain or request a specific quantity or dosage supply of pharmaceutical products.

The second step in *Metropolitan Life* looks to three factors. The second factor —whether the statute regulates an integral part of the policy relationship between the insurer

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[24]. TEX.INC.CODE.ANN. art. 21.52B note (West Supp. 1997).

and the insured—is met, since the statute directly regulates which pharmacist the beneficiary can select, and the quantity or dosage supply of pharmaceutical products. The third factor is also met, since, unlike the statute in *CIGNA*, the old statute is limited to insurance policies. It does not regulate entities outside the insurance industry. The first factor—whether the practice has the effect of spreading the policyholders' risk— requires further analysis. Prudential argues that this requirement is not met, particularly in light of the Supreme Court's decision in *Group Life & Health Ins. v. Royal Drug Co.*[25]

In *Royal Drug*, an appeal from the Fifth Circuit, the plaintiff pharmacies sued Blue Shield, an insurance company, for antitrust violations. Blue Shield claimed that its actions were exempt from the antitrust laws under the McCarran-Ferguson Act.[26]

In determining the ERISA savings clause, the Supreme Court has turned to case law interpreting the McCarran-Ferguson Act. This Act provides that state laws "regulating the business of Insurance" are not preempted by federal law.[27] We have held that deciding whether ERISA's savings clause exempts insurance regulation from preemption involves the same analysis used in deciding whether the regulation concerns the "business of insurance" under the McCarran-Ferguson Act. "The [ERISA] savings clause preserves the right of States, given by the McCarran-Ferguson Act, to regulate the 'business of insurance.' Consequently, to determine whether a State law is exempt from ERISA preemption, a court should examine the meaning of the phrase 'business of insurance' in the

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[25]. 440 U.S. 205, 99 S.Ct. 1067, 59 L.Ed.2d 261 (1979).

[26]. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48, 107 S.Ct. 1549, 1553, 95 L.Ed.2d 39 (1987).

[27]. 15 U.S.C. § 1012.

McCarran-Ferguson Act."[28]

In *Royal Drug*, Blue Shield had entered into pharmacy agreements with participating pharmacies in Texas, as Prudential has done in the present case. The agreements fixed prices and the method of reimbursement to the pharmacies. Insureds who went to participating pharmacies paid only $2 per prescription, and the pharmacies were then reimbursed by Blue Shield. If on the other hand the insured selected a pharmacy which did not have a agreement with Blue Shield, he was required to pay the full cost and then seek reimbursement from Blue Shield under a fixed formula. Blue Shield offered the pharmacy agreements to all licensed pharmacies in the state.[29]

The Court held that these agreements were not the business of insurance since they "do not involve any underwriting or spreading of risk, but are merely arrangements for the purchase of goods and services by Blue Shield."[30] The Court further reasoned that "the business of insurance relates to the contract between the insurer and the insured," and that the agreements in issue were separate contractual arrangements between Blue Shield and pharmacies.[31]

We conclude that *Royal Drug* is distinguishable. The focus of the Court in *Royal Drug* is clear: "The only issue before us is whether the Court of Appeals was correct in concluding that these Pharmacy Agreements are not the "business of insurance" within the meaning of s 2(b) of the

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[28]. *Gahn v. Allstate Life Ins. Co.*, 926 F.2d 1449, 1453 (5th Cir. 1991) (citations omitted).

[29]. *Royal Drug*, 440 U.S. at 209, 99 S.Ct. at 1072.

[30]. *Id.* at 214, 99 S.Ct. at 1075.

[31]. *Id.*at 215-216, 99 S.Ct. at 1075-1076.

McCarran-Ferguson Act."[32] The Court's ruling, in our view, turned on the fact that "[t]he Pharmacy Agreements are not "between the insurer and the insured,"[33] and the Court explained that "[t]his is not to say that the contracts offered by Blue Shield to its policyholders, as distinguished from its provider agreements with participating pharmacies, may not be the "business of insurance" within the meaning of the Act."[34]

Unlike the third-party pharmacy agreements in *Royal Drug*, the prior Texas statute directly regulated the terms of the insurance policy between the insurer and the insured. Both *Metropolitan Life* and *Royal Drug* explain that in enacting the McCarran-Ferguson Act Congress was concerned with: "The relationship between the insurer and insured, *the type of policy which could be issued*, its reliability, interpretation, and enforcement-----
these were the core of the "business of insurance."[35] *Metropolitan Life* goes on to state that "[n]or is there any contrary case authority suggesting that laws regulating the terms of insurance contracts should *not* be understood as laws that regulate insurance."[36]

The prior Texas statute regulated the type of policy

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[32]. *Id.* at 210, 99 S.Ct. at 1072.

[33]. *Id.* at 216, 99 S.Ct. at 1075.

[34]. *Id.* at 230 n. 37, 99 S.Ct. at 1082 n. 37.

[35]. *Metropolitan Life,* 471 U.S. at 744, 105 S.Ct. at 2391 (quoting *SEC v. National Securities, Inc.,* 393 U.S. 453, 460, 89 S.Ct. 564, 568-69, 21 L.Ed.2d 668 (1969); emphasis supplied in *Metropolitan Life; Royal Drug,* 440 U.S. at 215-16, 99 S.Ct. at 1075).

[36]. *Metropolitan Life,* 471 U.S. at 744, 105 S.Ct. at 2391 (emphasis in original).

which an insurer could offer in Texas. On this basis we find *Royal Drug* distinguishable. Further, we believe that the statute would affect the spreading of risks among policyholders and therefore meets the first requirement of the *Metropolitan Life* three-part test. By requiring policies to give the beneficiary the option of obtaining pharmaceutical services from any pharmacy, and requiring pharmacy networks to admit any willing provider, we believe that the prior statute influenced which costs were ultimately borne by the beneficiary, and whether insurers would be willing to offer pharmacy coverage at all.

In this regard, we agree with the reasoning of the Fourth Circuit In *Stuart Circle Hospital Corp. v. Aetna Health Management*.[37] In that case the court held that a Virginia any-willing-provider statute regulating PPOs was not preempted by ERISA. The court held that the statute had a sufficient effect on the spreading of policyholders risk to satisfy the *Metropolitan Life* test:

> If a PPO unreasonably restricts the providers of treatment, even though they meet the insurer's standards, it denies an insured the choice of doctor or hospital that may best suit the insured's needs, unless the insured is willing and able to pay all or part of the cost of the doctor or hospital that is not preferred by the insurer. This is a restriction of the insured's benefits. By its prohibition against unreasonable restriction of providers, the Virginia statute spreads the cost component of the policyholder's risk among all the insureds, instead of requiring the policyholder to shoulder all or part of this cost when seeking care or treatment from an excluded doctor or hospital of his or her choice.....[A]lthough facially the statute only directly affects providers, it indirectly affects the insured's choice of provider and the consequent cost to the insured if he or she deems an excluded provider

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[37]. 995 F.2d 500 (4th Cir. 1993).

to be better qualified for treatment of a specific illness or accident. In this way it affects the risk that an insured must bear.[38]

We agree with this analysis, and note that the prior Texas statute had an even more direct effect on the policyholder's choice of provider. Unlike the Virginia statute, the Texas statute expressly mandated that insurance policies cannot "prohibit or limit a person who is a beneficiary of the policy from selecting a pharmacy or pharmacist of the person's choice to be a provider under the policy to furnish pharmaceutical services offered or provided by that policy or interfere with that person's selection of a pharmacy or pharmacist."[39]

CONCLUSION

The judgment of the district court is affirmed insofar as it held that the statute, prior to the 1995 amendments, was not preempted by the federal ERISA statute. For the reasons explained above, however, we hold that the current version of the statute is preempted.

AFFIRMED AS MODIFIED.

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[38]. *Id.* at 503-04.

[39]. TEX.INS.CODE ANN. art. 21.52B, § 2(a)(1) (West Supp. 1997). This subsection was not changed by the 1995 amendments.

2. The Fifth Circuit's Order denying Appellees' Petition for Rehearing on March 17, 1997.

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 95-50807

U. S. COURT OF APPEALS
FILED
MAR 17 1997
CHARLES R FULBRUGEIII
CLERK

TEXAS PHARMACY ASSOCIATION, ET AL
Plaintiffs

TEXAS PHARMACY ASSOCIATION, formerly known as Texas Pharmaceutical Assn; RON'S APOTHECARY, INC.; TRI CITIES' PHARMACY, INC.; CITY PHARMACY; HAMLIN PHARMACY; ANDERSON DRUG; TWELVE OAK PHARMACY; SOUTH HOUSTON PHARMACY; DAVILA PHARMACY; MEDICAL CENTER PHARMACY; EILERS DISCOUNT PHARMACY; PROFESSIONAL PHARMACY; HART PHARMACY; MAYS HOMETOWN PHARMACY; WARD'S PHARMACY; GOOD'S PHARMACY; KLEIN'S DISCOUNT PHARMACY; AVONDALE PHARMACY; HOME CARE ASSOCIATES, INC.; WINN'S PHARMACY; TOMBALL ATRIUM PHARMACY; ROSEBUD PHARMACY; MAXWELL PHARMACY; SAVE-MOR #1 PHARMACY; MCCRORYIS PHARMACY; NICHOLS SOUTHSIDE PHARMACY; NICHOLS WESTWOOD PHARMACY; PFENNING PRESCRIPTION PHARMACY; BEL-AIRE DRUGS; S & L DRUG MART; PRESCRIPTION LAB OF SPRING BRANCH; ALL PLAINTIFFS
Plaintiffs - Appellees

v.

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA
Defendant - Appellant

Appeal from the United States District Court for the Western District Of Texas, Austin

---

ON PETITION FOR REHEARING

Before REAVLEY, GARWOOD and BENAVIDES, Circuit Judges.

PER CURIAM:

IT IS ORDERED that the petition for rehearing filed in the above case is *denied*

(original "denied" handwritten)

ENTERED FOR THE COURT:

/s/_____

UNITED STATES CIRCUIT JUDGE

CLERK'S NOTE:
SEE FRAP AND LOCAL RULES 41 FOR STAY OF THE MANDATE

3. The Judgment of the Fifth Circuit Court of Appeals on which review is sought.

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 95-50807

MAR 27 2 21 PM '97
U.S. CLERKS OFFICE
BY /s/_____
DEPUTY

U. S. COURT OF APPEALS
FILED
FEB 14 1997
CHARLES R FULBRUGEIII
CLERK

TEXAS PHARMACY ASSOCIATION, ET AL
Plaintiffs

TEXAS PHARMACY ASSOCIATION, formerly known as Texas Pharmaceutical Assn; RON'S APOTHECARY, INC.; TRI CITIES' PHARMACY, INC.; CITY PHARMACY; HAMLIN PHARMACY; ANDERSON DRUG; TWELVE OAK PHARMACY; SOUTH HOUSTON PHARMACY; DAVILA PHARMACY; MEDICAL CENTER PHARMACY; EILERS DISCOUNT PHARMACY; PROFESSIONAL PHARMACY; HART PHARMACY; MAYS HOMETOWN PHARMACY; WARD'S PHARMACY; GOOD'S PHARMACY; KLEIN'S DISCOUNT PHARMACY; AVONDALE PHARMACY; HOME CARE ASSOCIATES, INC.; WINN'S PHARMACY; TOMBALL ATRIUM PHARMACY; ROSEBUD PHARMACY; MAXWELL PHARMACY; SAVE-MOR #1 PHARMACY; MCCRORYIS PHARMACY; NICHOLS SOUTHSIDE PHARMACY; NICHOLS WESTWOOD PHARMACY; PFENNING PRESCRIPTION PHARMACY; BEL-AIRE DRUGS; S & L DRUG MART; PRESCRIPTION LAB OF SPRING BRANCH; ALL PLAINTIFFS
Plaintiffs - Appellees

v.

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA
Defendant - Appellant

Appeal from the United States District Court for the
Western District Of Texas, Austin

J U D G E M E N T

This cause came on to be heard on the record on appeal and was argued by counsel.

ON CONSIDERATION WHEREOF, it is now here ordered and adjudged by this Court that the judgment of the District Court in this cause is affirmed as modified.

IT IS FURTHER ORDERED that defendant-appellant pay to plaintiffs-appellees the costs on appeal to be taxed by the Clerk of this Court.

ISSUED AS MANDATE: MAR 2 5 1997

OP-OA-J-1

A true copy
Test

Clerk U. S. Court of Appeals, Fifth Circuit

By /s/ _____
Deputy
New Orleans, Louisiana MAR 25 1997

4. **Texas Insurance Code, Article 21.52B (Vernon 1994) and Historical and Statutory Notes.**

Art. 21.52B Pharmaceutical Services

Definitions

Sec. 1. In this article:

(1) "Health insurance policy." means an individual, group, blanket, or franchise insurance policy, insurance policy or agreement, or group hospital service contract that provides benefits for pharmaceutical services that are necessary as a result of or to prevent an accident or sickness, but does not include evidence of coverage provided by a health maintenance organization under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon'a Texas Insurance Code).

(2) "Pharmaceutical services" means services, including dispensing prescription drugs, that are ordinarily and customarily rendered by a pharmacy or pharmacist licensed to practice pharmacy under the Texas Pharmacy Act (Article 4542a-1, Vernon's Texas Civil Statutes).

(3) "Pharmacist" means a person licensed to practice pharmacy under the Texas Pharmacy Act (Article 4542a-1, Vernon's Texas Civil Statutes).

(4) "Pharmacy" means a facility licensed as a pharmacy under the Texas Pharmacy Act (Article 4542a-1, Vernon's Texas Civil Statutes).

(5) "Drugs" and "prescription drugs" have the meanings assigned by Section 5, Texas Pharmacy Act (Article 4542a-1, Vernon's Texas Civil Statutes).

Prohibited contractual provisions

Sec. 2. (a) A health insurance policy that is delivered, issued for delivery, or renewed or for which a contract is executed may not:

(1) prohibit or limit a person who is a beneficiary of the policy from selecting a pharmacy or pharmacist of the person's choice to be a provider' under the policy to furnish pharmaceutical services offered or provided by that policy or interfere with that person's selection of a pharmacy or pharmacist;

(2) deny a pharmacy or pharmacist the right to participate as a contract; provider under the policy if the pharmacy or pharmacist agrees to provide pharmaceutical

services that meet all terms and requirements and to include the same administrative, financial, and professional conditions that apply to pharmacies and pharmacists who have been designated as providers under the policy; or

(3) require a beneficiary of a policy to obtain or request a specific quantity or dosage supply of pharmaceutical products, but the policy may allow the beneficiary's physician to prescribe drugs in a quantity or dosage supply the physician determines appropriate and that is in compliance with state and federal statutes.

(b) This section does not prohibit:

(1) a provision of a policy from limiting the quantity or dosage supply of pharmaceutical products for which coverage is provided or providing financial incentives to encourage the beneficiary and prescribing physician to use a program that provides pharmaceutical products in quantities that result in cost savings to the insurance plan and beneficiary if the provision applies equally to all designated providers of pharmaceutical services under the policy; or

(2) a pharmacy card program that provides a means of-obtaining pharmaceutical services offered by the policy through all designated providers of pharmaceutical services.

Provision void

Sec 3. A provision of a health insurance policy that is delivered, issued for delivery, or renewed in this state that conflicts with Section 2 of this article is void to the extent of the conflict.

Construction of article

Sec. 4. This article does not require a health insurance policy to provide pharmaceutical services.

Application of prohibition

Sec. 5. The provisions of Section 2 of this article do not apply to a self-insured employee benefit plan that is subject to the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001, et seq.).

Sec 6. Repealed by Acts 1993, 73rd Leg., ch. 685, § 19.06, off.. Aug. 30, 1993.

Added by Acts 1991, 72nd Leg., ch. 182, § 1, eff. Sept. 1, 1991. Sec. 2(b) amended by Acts 1993, 73rd Leg, ch. 685, § 19.07, elf.. Sept. 1, 1993; Sec. 5 amended by Acts 1993, 73rd Leg., ch. 685, § 19.08, elf.Sept. 1, 1993; Sec. 6 repealed by Acts 1993, 73rd Leg., ch. 685, § 19.06, elf.. Aug. 30, 1993.

Historical and Statutory Notes

Sections 2 and 3 of the 1991 Act provide:

"Sec. 2. This Act takes effect September 1, 1991, and applies to coverage provided by health insurance policies delivered, issued for delivery, or renewed on or after January 1, 1992. Policies delivered, issued for delivery, or renewed before January 1, 1992, are governed by the law that existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

"Sec. 3. If any provision of this Act or if application to any person or circumstance is held invalid, this entire Act is invalid and to that end the provisions of this Act are not severable."

Section 12 of Acts 1993, 73rd Leg., ch. 607 provides:

To the Intent that any provision of this law conflicts with Article 20.11, 21.52, 21.52B, or 21.53, Insurance Code, or with Section 14, Texas Health Maintenance Organization Act (Article 20A.14, Vernor.'s Texas Insurance Code), the provisions of Article 20.11, 21.52, 21.52B, or 21 53, Insurance Code. or Section 14. Texas Health Maintenance Organization Act (Article 20A.14, Vernon's Texas Insurance Code), as appropriate, shall prevail."

Section 19.09 of Acts 1993, 73rd Leg., ch. 685 provides:

"(a) The Legislature hereby creates an interim select committee to study the impact of requiring a health insurance policy or health maintenance organization to allow any qualified provider who is a physician, physician's assistant, advanced nurse practitioner, or any class of provider enumerated in Articles 21.52 and 21.52B, Insurance Code, to participate as a contracting provider for such policy or plan.

"(b) The committee is composed of:

"(1) three members of the senate, appointed by the lieutenant governor, and

"(2) three members of the house of representatives, appointed by the speaker of the house of representative.

"(c) Not later than December 1, 1994, the committee shall report its findings and any recommeniations for changes in the law to the 74th Legislature."

5. Texas Insurance Code, Article 21.52B (Vernon 1997) and Historical and Statutory Notes.

Art. 21.52B. Pharmaceutical Services

Definitions

Sec. 1. In this article:

(1) "Health insurance policy" means an individual, group, blanket, or franchise insurance policy, insurance-policy or agreement, or group hospital service contract that provides benefits for pharmaceutical services that are necessary as a result of or to prevent an accident or sickness, but does not include evidence of coverage provided by a health maintenance organization under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code).

(2) "Pharmaceutical services" means services, including dispensing prescription drugs, that are ordinarily and customarily rendered by a pharmacy or pharmacist licensed to practice pharmacy under the Texas Pharmacy Act (Article 4542a-1, Vernon's Texas Civil Statutes).

(3) "Pharmacist" means a person licensed to practice pharmacy under the Texas Pharmacy Act (Article 4542a-1, Vernon's Texas Civil Statutes).

(4) "Pharmacy" means a facility licensed as a pharmacy under the Texas Pharmacy Act (Article 4542a-1, Vernon's Texas Civil Statutes).

(5) "Drugs" and "prescription drugs" have the meanings assigned by Section 5, Texas Pharmacy Act (Article 4542a-1, Vernon's Texas Civil Statutes).

(6) "Managed care plan" means a health maintenance organization, a preferred provider organization, or another organization that, under a contract or other agreement entered into with a participant in the plan:

(A) provides health care benefits, or arranges for health care benefits to be provided, to a participant in the plan; and

(B) requires or encourages those participants to use health care providers designated by the plan.

Prohibited contractual provisions

Sec. 2. (a) A health insurance policy or managed care

plan that is delivered, issued for delivery, or renewed or for which a contract or other agreement is executed may not:

(1) prohibit or limit a person who is a beneficiary of the policy from selecting a pharmacy or pharmacist of the person's choice to be a provider under the policy to furnish pharmaceutical services offered or provided by that policy or interfere with that person's selection of a pharmacy or pharmacist;

(2) deny a pharmacy or pharmacist the right to participate as a contract provider under the policy or plan if the pharmacy or pharmacist agrees to provide pharmaceutical services that meet all terms and requirements and to include the same administrative, financial, and professional conditions that apply to pharmacies and pharmacists who have been designated as providers under the policy or plan; or

(3) require a beneficiary of a policy or a participant in a plan to obtain or request a specific quantity or dosage supply of pharmaceutical products.

(b)Notwithstanding Subsection (a)(3) of this section, a health insurance policy or managed care plan may allow the physician of a beneficiary or participant to prescribe drugs in a quantity or dosage supply the physician determines appropriate and that is in compliance with state and federal statutes.

(c) This section does not prohibit:

(1) a provision of a policy or plan from limiting the quantity or dosage supply of pharmaceutical products for which coverage is provided or providing financial incentives to encourage the beneficiary or participant and the prescribing physician to use a program that provides pharmaceutical products in quantities that result in cost savings to the insurance program or managed care plan and the beneficiary or participant if the provision applies equally to all designated providers of pharmaceutical services under the policy or plan;

(2) a pharmacy card program that provides a means of obtaining pharmaceutical services offered by the policy or plan through all designated providers of pharmaceutical services; or

(3) a plan from establishing reasonable application and recertification fees for a pharmacy which provides pharmaceutical services as a contract provider under the plan, provided that such fees are uniformly charged to each pharmacy under contract to the plan.

Provision void

Sec. 3. A provision of a health insurance policy or managed care plan that is delivered, issued for delivery, entered into, or renewed in this state that conflicts with Section 2 of this article is void to the extent of the conflict.

Construction of article

Sec. 4. This article does not require a health insurance policy or managed care plan to provide pharmaceutical services.

Application of prohibition

Sec. 5. The provisions of Section 2 of this article do not apply to a self-insured employee benefit plan that is subject to the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001, et seq.).

Sec. 6. Repealed by Acts 1993, 73rd Leg., ch. 685, § 19.06, elf. Aug. 30, 1993.

Added by Acts 1991, 72nd Leg., ch. 182, § 1, eff. Sept. 1, 1991. Sec. 2(b) amended by Acts 1993, 73rd Leg., ch. 685, § 19.07, off.. Sept. 1, 1993; Sec. 5 amended by Acts 1993, 73rd Leg., ch. 685, § 19.08, eff. Sept. 1, 1993; Sec. 6 repealed by Acts 1993, 73rd Leg., ch. 685, § 19.06, eff. Aug. 30, 1993; Sec. 1(6) added by Acts 1995, 74th Leg., ch. 852, § 1, elf.. Sept. 1, 1995; Sec. 2 amended by Acts 1995, 74th Leg., ch. 852, § 2, elf.. Sept. 1, 1995; Sec. 3 amended by Acts 1995, 74th Leg., ch. 852, § 3, Off.. Sept. 1, 1995; Sec. 4 amended by Acts 1995, 74th Leg., ch. 852, § 4, eff. Sept. 1, 1995.

Historical and Statutory Notes

Sections 2 and 3 of the 1991 Act provide:

"Sec. 2. This Act takes effect September 1, 1991, and applies to coverage provided by health insurance policies

delivered, issued for delivery, or renewed on or after January 1, 1992. Policies delivered, issued for delivery, or renewed before January 1, 1992, are governed by the law that existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

"Sec. 3. If any provision of this Act or if application to any person or circumstance is held invalid, this entire Act is invalid and to that end the provisions of this Act are not severable."

Section 12 of Acts 1993, 73rd Leg., ch.607 provides:

"To the extent that any provision of this law conflicts with Article 20.11, 21.52, 21.52B, or 21.53, Insurance Code, or with Section 14, Texas Health Maintenance Organization Act (Article 20A.14, Vernon's Texas Insurance Code), the provisions of Article 20.11, 21.52, 21.52B, or 21.53, Insurance Code, or Section 14, Texas Health Maintenance Organization Act (Article 20A.14, Vernon's Texas Insurance Code), as appropriate, shall prevail."

Section 19.09 of Acts 1993, 73rd Leg., ch. 685 provides:

"(a) The Legislature hereby creates an interim select committee to study the impact of requiring a health insurance policy or health maintenance organization to allow any qualified provider who is a physician, physician's assistant, advanced nurse practitioner, or any class of provider enumerated in Articles 21.52 and 21.52B, Insurance Code, to participate as a contracting provider for such policy or plan.

"(b) The committee is composed of:

"(1) three members of the senate, appoints by the lieutenant governor; and

"(2) three members of the house of representatives, appointed by the speaker of the house of representatives.

"(c) Not later than December 1, 1994, the committee shall report its findings and any recommendations for changes in the law to the 74th Legislature."

Sections 6 and 7 of the 1995 amendatory act provide:

"Sec. 6. (a) The provisions of this Act do not apply to:

"(1) a group model health maintenance organization

that is a state certified health maintenance organization that provides the majority of its professional services through a single group medical practice that is formally affiliated with the medical school component of a Texas state supported public college or university and that received its certification as a health maintenance organization prior to November 1, 1981; or

"(2) a nonprofit group practice model health maintenance organization that provides pharmaceutical services to its enrollees only through pharmacies located at medical offices owned, leased, or contracted for by the health maintenance organization and that received its certification prior to November 1, 1985.

"Sec. 7. This Act takes effect September 1, 1995, and applies only to an insurance policy or evidence of coverage under a managed care plan that is delivered, issued for delivery, or renewed on or after January 1, 1996. A policy or evidence of coverage that is delivered, issued for delivery, or renewed before January 1, 1996, is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose."

6. 29 U.S.C. § 1144(a) & (b)(2)(A) (West 1985).

§ 1144. Other Laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

7. Texas Government Code, Section 311.032(c) (Vernon 1988).

§ 311.032. Severability of Statutes

(a) If any statute contains a provision for severability, that provision prevails in interpreting that statute.

(b) If any statute contains a provision for nonseverability, that provision prevails in interpreting that statute.

(c) In a statute that does not contain a provision for severability or nonseverability, if any provision of the statute or its application to any person invalid, the invalidity does not affect other provisions or applications of the statute that can be given effect without the invalid provision or application, and to this end the provisions of the statute are severable.

Acts 1985, 69th Leg., ch. 479, § 1, eff. Sept. 1, 1985.

Historical Note

Prior Law:

Acts 1967, 60th Leg., p. 1036, ch. 455, § 1.
Vernon's Ann.Civ.St. art. 5429b-2, § 3.12.

8. Texas Government Code, Section 311.025 (Vernon 1988).

§ 311.025. Irreconcilable Statutes and Amendments

(a) Except as provided by Section 311.031(d), if statutes enacted at the same or different sessions of the legislature are irreconcilable, the statute latest in date of enactment prevails.

(b) Except as provided by Section 311-031(d), if amendments to the same statute are enacted at the same session of the legislature, one amendment without reference to another, the amendments shall be harmonized, if possible, so that effect may be given to each. If the amendments are irreconcilable, the latest in date of enactment prevails.

Acts 1985, 69th Leg., ch. 479, §1, eff. Sept. 1, 1985.

Historical Note

Prior Law:

Acts 1967, 60th Leg., p. 1036, ch. 455, § 1.
Vernon's Ann.Civ.St. art. 5429b-2, § 3.05.

9. Texas Government Code, Section 312.013 (Vernon 1988).

§ 312.013. Severability of Statutes

(a) Unless expressly provided otherwise, if any provision of a statute or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the statute that can be given effect without the invalid provision or application, and to this end the provisions of the statute are severable.

(b) This section does not affect the power or duty of a court to ascertain and give effect to legislative intent concerning severability of a statute.

Acts 1985, 69th Leg., ch. 479, § 1, eff. Sept. 1, 1985.

Historical Notes

Prior Law:

Acts 1967, 60th Leg, P. 1036, ch. 455, § 1.
Vernon's Ann. Civ. St. art. 5429-2, § 3.12.

No. 96-2001

Supreme Court, U.S.
FILED
AUG 18 1997
CLERK

In The

Supreme Court of the United States

October Term, 1996

TEXAS PHARMACY ASSOCIATION, *et al.*,

Petitioners,

vs.

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA,

Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

RESPONDENT'S BRIEF IN OPPOSITION

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71817 (800) 3 APPEAL • (800) 5 APPEAL • (800) BRIEF21 Lutz Appellate Services, inc.

QUESTIONS PRESENTED

1. The United States Court of Appeals for the Fifth Circuit held that the Texas statute here at issue (Article 21.52B of the Insurance Code (Vernon Supp. 1994)), (hereafter the "Statute"), regulated: (a) entities that are not insurance companies; and (b) contracts between such entities and ERISA plans pursuant to which: (i) there was no insurance; and (ii) the regulated entities functioned solely in an administrative capacity to such plans. As there is no decision by this Court, or by any Circuit Court of Appeals, which holds that a state law such as the Statute is not subject to preemption pursuant to ERISA's preemption clause, 29 U.S.C. § 1144 (a) or, if so subject, is saved from preemption pursuant to ERISA's "Savings Clause," 29 U.S.C. § 1144(b)(2)(A), the question presented is whether there is a conflict between lower court precedent for the Court to resolve?

2. In *CIGNA Healthplan of Louisiana, Inc. v. Louisiana ex rel. Ieyoub*, 82 F.3d 642 (5th Cir.), *cert. denied*, 117 S. Ct. 387 (1996) (hereafter, "*CIGNA*"), a Louisiana statute substantively identical for all presently relevant and material purposes to the Statute, was held by the Fifth Circuit to be subject to ERISA preemption pursuant to and not saved from such preemption by virtue of 29 U.S.C. § 1144(b)(2)(A). This Court declined to review the decision of the Fifth Circuit's decision in *CIGNA* on November 4, 1996, and the question presented is whether there is any objective reason or necessity for this Court to now come to a different conclusion in this case?

3. The decision in *Stuart Circle Hospital Corp. v. Aetna Health Management*, 995 F.2d 500 (4th Cir.), *cert. denied*, 510 U.S. 1003 (1993) involved a Virginia statute that regulated only: (a) insurance companies; (b) PPOs (preferred provider organizations) owned by insurance companies; and (c) the terms and provisions of insurance policies. *Id.* at 502. No term or

provision of the Virginia statute regulated uninsured administrative arrangements or other fiduciary relationships between ERISA health and welfare plans and any entity. The Statute, in contrast, regulates non-insurance entities and uninsured relationships. The Statute goes so far as to purport in uninsured contexts, to empower ERISA plan participants to freely choose their own pharmacy provider notwithstanding a decision by either their plans' sponsors or a plan fiduciary that a restricted network best serves the plan's needs, interests and requirements. Art. 21.52B § 7(a)(1)3. The question presented is whether, given the great substantive disparity between the scope and effects the Texas statute here at issue and the Virginia law at issue in *Stuart Circle*, the differing conclusions respecting the applicability of ERISA's preemption and insurance savings clauses reached by the Fourth and Fifth Circuit Courts of Appeal constitute a "conflict" under any sensible definition or understanding of that term?

4. In *Blue Cross and Blue Shield of Kansas City v. Bell*, 798 F.2d 1331 (10th Cir. 1986) the issue resolved, as described by the Petition, was whether "an insured's choice of a provider was the essence of the coverage bargained for as the statute operated to spread or transfer the policyholder's risk. *Id.* at 1335." [1] The Statute at issue here is not limited to insurers, insurance policies or to circumstances in which there is a spread or transfer of insurance risk. The Statute regulates uninsured settings and relationships as well as entities which are not either insurers or functioning as insurers. The question presented, therefore, is whether, given the plain and relevant disparities between the statutory issues presented in *Bell* and those

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1. *Petition for Writ of Certiorari*, at p. 12. Respondent does not dispute Petitioner's description of the issue that was resolved in *Bell*. This concurrence is not intended to suggest that The Prudential believes that the decision was sound.

presented in this case, a conflict between the Fifth and Tenth Circuit Courts of Appeal fairly and accurately may be asserted to exist?

5. Whether Petitioner's request that the Court review the Texas statute in its initial form as if it had not been amended by the Texas legislature, and thus effectively disregard its current and effective terms and provisions, amounts to a request for an advisory opinion as to a hypothetical circumstance?

STATEMENT PURSUANT TO RULE 29.6

The Prudential Insurance Company of America is the parent company of only wholly owned subsidiaries of The Prudential Insurance Company of America.

COUNTERSTATEMENT OF THE CASE

Petitioners' *Statement of the Case* is inadequate, and thus potentially misleading, in a material respect. The Prudential Insurance Company of America's (hereafter, "The Prudential") activities in Texas asserted to be subject to the Statute include the provision of administrative services to ERISA plans. R. at 00084-00087; R. at 00088-00090. These relationships commonly are known as "ASO" contracts. In such ASO contract relationships, The Prudential provides plan administration and claims processing services to ERISA plans. It does not assume or accept any transfer of risk with respect to these plans' covered benefits. The substantial majority of The Prudential's membership in Texas consists of ERISA plan participants and beneficiaries. R. at 00080-00090.

In the performance of its contractual plan administration and claims processing obligations, The Prudential frequently functions in a fiduciary capacity within the meaning of ERISA. *See Arkansas Blue Cross and Blue Shield v. St. Mary's Hosp., Inc.*, 947 F.2d 1341, 1346 (8th Cir. 1991), *cert. denied*, 504 U.S. 957 (1992); *Benvenuto v. Connecticut Gen. Life. Ins. Co.*, 643 F. Supp. 87, 90 (D.N.J. 1986). The Statute is prescriptive as to the criteria The Prudential must apply when it is functioning in the capacity of an administrator for a self-funded ERISA plan with respect to: (a) pharmacy benefit delivery design structures; (b) selection of the providers who will be entitled to be compensated with plan assets for services to plan participants and beneficiaries; and (c) how to achieve the most economically and administratively prudent approaches to contracting with pharmacy providers to which the plan will become liable. R. at 02057-02060.

Because of the Statute, self-funded ERISA plans which desire to utilize a restricted pharmacy provider network for either

economic or administrative efficiency reasons, or both, cannot utilize the services of a third-party[2] experienced in the creation and management of such networks. The single means permitted by the Statute through which a self-funded ERISA health and welfare plan can limit the delivery of pharmacy benefits to an identified network of pharmacies requires the plan to itself organize and manage the network. Although it is pertinent that such an undertaking may or may not be either prudent or feasible for a given plan, Petitioner's disregard of this factual effect of the Statute obscures a material legal issue, *i.e.*, whether under ERISA's preemption clause a state law may deny to ERISA plans and their fiduciaries all plan administration choices but one from those that otherwise would be available and plausible options. There is no case decided by any Court of Appeals which holds that ERISA does not preempt a state law that denies administrative and plan design choices to ERISA plans[3] and their fiduciaries. Thus, Petitioners factual omissions mask the circumstance that the decision of the Fifth Circuit in this case is consistent, and not at all in conflict, with all existing relevant precedent.

REASONS FOR DENYING THE WRIT

There are three simple and straightforward reasons why this case does not warrant review by the Court.

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2. Art. 21.52(B) § (6) refers, and thus makes the Statute applicable to, what it calls "another organization." There is no elucidation or explanation in the Statute or in regulations as to the identity or defining characteristics of the entities which constitute such an organization.

3. The Court's decision in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 115 S. Ct. 1671, 1674, 1678-80 (1995), references and affirms the Court's prior decisions that ERISA's preemption clause denies to the states any ability to interfere with either ERISA plan fiduciary functions or with plan structure, administration or organizational issues and matters.

First, there is no relevant material distinction between the Texas statute at issue in this case and the Louisiana statute at issue in *CIGNA*. Nor is there any material distinction in either the holdings, or the reasoning in support thereof, of the Fifth Circuit Court Appeals in this case and in *CIGNA*. Indeed, in this case, the Fifth Circuit holds that its ruling is "compelled by our recent decision in *CIGNA*." *Texas Pharmacy Ass'n v. The Prudential Ins. Co. of America*, 105 F.3d 1035, 1038 (5th Cir. 1997). Petitioners have not identified any new decision, or other pertinent development since the Court determined last November that the decision in *CIGNA* did not warrant review that calls for a different result here.

Second, as fairly appears from the immediately preceding "Questions Presented" section, Petitioners' assertion that there is a conflict between the Circuits wholly lacks foundation. The Fourth and Tenth Circuits decisions upon which Petitioners depend to create the appearance of a conflict, *Stuart Circle* and *Bell*, both involve materially distinguishable statutes, issues and circumstances. Neither *Stuart Circle* nor *Bell* involve the applicability of a state statute to an uninsured relationship. In contrast, the Statute plainly regulates uninsured relationships between ERISA plans and entities which perform plan administration and claims processing functions affecting the disposition of such plans' assets as distinguished from an insurer's own assets. Neither *Stuart Circle* nor *Bell* stand for the proposition that ERISA does not preempt a state's attempt to regulate such ERISA plan relationships and functions.

Third, the Petition seeks review of a hypothetical statute which no longer exists. Petitioners request the Court to consider the Statute as is was before it was amended. The former statute was limited in its reach to insurance companies and to insurance coverage. In effect, Petitioners blink away the reality that the Statute was amended to extend its regulatory scope far beyond

insurance companies and insured relationships. In effect, Petitioners present a bare hypothetical issue.

Assuming, arguendo, that it were appropriate to request the Court to issue what amounts to no more than an advisory opinion as to a hypothetical statute, the Fifth Circuit's decision in this case establishes that there would be no conflict between the Courts of Appeal for this Court to resolve. In a frankly curious portion of its decision, the Fifth Circuit addressed the ERISA preemption issues as they would apply to what it refers to as "*The Prior Statute*." *Texas Pharmacy Ass'n*, 105 F.3d at 1040. The unique quality of this undertaking is signaled by the opening sentence of the analysis which states: "We question whether a ruling on the validity of the old statute is of much value to the parties, . . . [.]" *Id.*

Whether the Fifth Circuit should have addressed a non-existent statute may be an issue for another time. What is pertinent for present purposes, however, is that the opinion below expresses agreement "with the reasoning of the Fourth Circuit in *Stuart Circle Hospital Corp. v. Aetna Health Management* . . . [.]" *Id.* at 1041. It then is speculatively opined that the "prior statute" would have been saved from ERISA preemption by virtue of the Savings Clause. 29 U.S.C. § 1144(b)(2)(A).

The result of the Fifth Circuit's examination of a moot statute, of course, is that Petitioner's contention that there is a conflict between the Circuits has been completely undermined and is untenable. The Fifth Circuit's opinion clearly establishes that there is no conflict between it and any other Circuit Court as to the issue whether a state statute which only regulates insurance companies and the contents of insurance policies in insured relationships with respect to provider networks is preempted by ERISA.

If the Court believed that the decisions in *Stuart Circle* and *Bell*, as well as the speculative portion of the decision below, require review and correction, that, of course, would constitute a reason to grant the Petition. There is no substance, however, to the Petitioner's contention that there is a conflict in the relevant case precedent that requires the intervention of the Court.

CONCLUSION

For these reasons, it respectfully is submitted that the *Petition for Writ of Certiorari from The United States Court of Appeals For The Fifth Circuit* should be denied.

Respectfully Submitted,

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